Equipment Request NAVMED 6700/12

1. Medical or Dental Facility (Name and City):	UIC:	ECN:
Branch Medical/Dental Clinic:	Branch UIC:	Date:
Requesting Dept/Div:	Dept/Div Code:	Command Priority:
Standard Nomenclature:		Equip Type Code:

2. Item Description: (How the equipment will be used with general description and characteristics including **ALL** components and accessories.) (Use additional sheets if required.) (Attach manufacturer's literature and quotation.)

Suggested Mfr. _____ Model No. _____ Acquisition Cost $_____
(Cost includes accessories, installation and facility modification.)

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COMMAND: _____ UIC: _____ ECN: _____

3. JUSTIFICATION. (Use additional sheets to answer each question. Indicate command name, ECN and the question you are answering on each page. For timely consideration, ensure your submission contains all information requested.)

a. Cost/Benefit Analysis (Reference DoD Instruction 7041.3, Economic Analysis for Decision Making). The economic analysis report should begin with a summary of the analysis (based on the benefits and costs of the alternatives), and an interpretation of the results (to include a recommendation of the preferred alternative). The actual decision is based on qualitative as well as quantitative factors. The results of the economic analysis, including all calculations and sources of data, must be documented down to the most basic inputs to provide an audible and stand-alone document.

(1) The purpose of the economic analysis is to give the decision makers (NMLC, BUMED, & SG Specialty Leaders) insight into economic factors bearing on accomplishing the objectives. Therefore, it is important to identify factors, such as cost and performance risks and drivers, which can be used to establish and defend priorities and resource allocations. Your economic analysis of investment alternatives must include the five elements listed in (2) – (6).

(2) **OBJECTIVE**: Clearly define and quantify the function to be accomplished with requested equipment.

(3) **ASSUMPTIONS**: Base economic analysis on facts and data when possible. Since economic analysis deals with costs and benefits occurring in the future, assumptions must be made to account for uncertainties. (At a minimum, provide 2 years workload history and 2 years of projected workload. Rational for increases must be included).

(4) **ALTERNATIVES**: Feasible ways of satisfying the objective **must be** documented and discussed. (i.e., cost to refurbish old equipment, CHAMPUS, Supplemental Care, use of neighboring MTF's equipment, similar equipment in your facility that you might use, etc.)

(5) **COSTS AND BENEFITS**: List the costs and benefits associated with each alternative. (i.e., include an analysis addressing costs per procedure under each alternative.)

(6) **COMPARISON OF ALTERNATIVES**: Compare the costs and benefits of each alternative and rank them according to net present value. **You must evaluate and document leasing options.**

b. How is the function of the item currently being accomplished?

c. Will additional staffing be required? Include current mix and experience of departmental staffing.

3. JUSTIFICATION (cont.)

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COMMAND: _____ UIC: _____ ECN: _____

d. Mission impact if not funded in the fiscal year requested.

e. Will requested item be used in conjunction with other equipment within the entire facility (existing or proposed)? If Yes, Explain.

f. Is operator training required? (Describe)

g. Is this requirement a result of a Business Process Reengineering initiative? If yes, discuss results and recommendations.

h. Additional information as needed.

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COMMAND: _____ UIC: _____ ECN: _____

4. Equipment is __ New; __ Expansion; __ Replacement; __ Upgrade. If replacement/upgrade, complete the following:

a. Item being replaced/upgraded: Nomenclature _____ Manufacturer_____

Model No. _____ Serial No. _____ Plant Account No. _____

b. Proposed disposition of replaced equipment; __ Dispose; __ Excess to command; __ Retain. Why retain?

5. Requesting Department Head

_____

Typed name/signature of DH Phone No./Date

6. Is an ASDP required? _____ Yes (attach copy)

_____ No

_____

Typed name/signature of Head, MID Date

7. Facilities Manager:

a. Is facility modification required (i.e., additional electrical support; plumbing (water, steam, drainage); emergency power; gas (air, O_2, vacuum); exhaust; additional heating, A/C, ventilation; radiation shielding)?

____ Yes ____ No (If yes, estimated cost.) $_____

b. Is installation required? ____ Yes ____ No (If yes, estimated cost.) $_____

c. Are M2/R2 dollars required for installation? ____ Yes ____ No (If yes, are they available? ____ Yes ____ No)

d. Are there any environmental impacts due to the proposed request (i.e., more hazardous waste generated, increased noise levels, radiation, ozone depleting substances, etc.)?

e. Additional considerations not previously mentioned. (Use additional sheet if required.)

_____

Typed name/signature of Facilities Manager Phone No.

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COMMAND: _____ UIC: _____ ECN: _____

8. Biomedical Engineering Representative:

a. Maintenance/repairs will be provided by: ____ In-house BMET. (Is additional training required?)

_____ Yes _____ No ____ Commercial contract. (Estimated cost) $_____

b. To be completed for replaced equip: Month/Yr installed _____ Life expectancy _____Condition Code _____

Total Man-hours expended: Preventive maintenance _____ Corrective maintenance _____

Cost of repair parts and service to date. $_____ Cost of maintenance services to date. $_____

Is maintenance record (NAVMED 6700/3 or BIOFACS maintenance record) available? ____ Yes ____ No

If No, why not?

_____

_____

Typed name/signature of Biomedical Engineering Representative Phone No.

9. Are there any OSHA requirements? ____ Yes ____ No
If yes, attach addendum. (See NAVMED P-5132, Annex 4.)

_____

Typed name/signature of Safety Officer Date

10. Reviewed by Equipment Program Review Committee

_____

Typed name/signature of Chairman Date

11. Type of funding: __ OP __ FIP __ IH __Lease __O&M __Collateral

_____

Typed name/signature of Comptroller Date

_____

Typed name/signature of Equipment Manager Date

12. Commanding Officer

_____

Typed name/signature Date

13. HSO, NEHC, or NSHS Review

_____

Typed name/signature of Reviewer Date

NAVMED 6700/12 (REV 1/98)

INSTRUCTIONS FOR PREPARING EQUIPMENT REQUEST (NAVMED 6700/12)

BLOCK 1:
Medical or Dental Facility (Name and City): Provide complete command name and city for the appropriate facility. Do not use local names. This is not where a branch clinic is indicated. This is the hospital or dental command that has the responsibility of the branch clinic.
UIC (Unit Identification Code): Provide UIC for the Medical or Dental Facility.
ECN (Equipment Control Number): Provide unique six digit number assigned for each individual item. Sometimes these numbers are assigned by the Equipment Manager. See Page 3-14 of this manual for assigning ECNs.
Branch Medical/Dental Clinic: Provide the name, base and city for the branch medical or dental clinic for which the equipment request is ultimately for. Do not use local names. *LEAVE BLANK IF REQUEST IS NOT FOR A BRANCH MEDICAL OR DENTAL CLINIC*.
Branch UIC: Provide the UIC for the branch medical or dental clinic indicated in the previous block. *LEAVE BLANK IF REQUEST IS NOT FOR A BRANCH MEDICAL OR DENTAL CLINIC.*
Date: Use current date.
Requesting Dept/Div: Provide name of department and division requesting the equipment.
Dept/Div Code: *TO BE COMPLETED BY THE EQUIPMENT MANAGER.* Provide the appropriate department or division code from Annex 11.
Command Priority: *TO BE COMPLETED BY THE EQUIPMENT MANAGER AFTER THE EQUIPMENT PROGRAM REVIEW COMMITTEE MEETS.* Provide the command's priority for the appropriation year budget submission.
Standard Nomenclature: *TO BE COMPLETED BY THE EQUIPMENT MANAGER.* Provide the standard nomenclature from Annex 25. If the request is for an"upgrade" use the standard nomenclature and add "(UPGRADE)" at the end. If the request is for a "system" use the standard nomenclature and add "(SYS)" at the end.
Equip Type Code: *TO BE COMPLETED BY THE EQUIPMENT MANAGER.* Use the appropriate Equipment Type Code provided in Annex 25.

BLOCK 2:
Item Description: Provide a general description and characteristics including ALL components and accessories.
Suggested Mfr/Model No/Acquisition Cost: For planning purposes, a suggested manufacturer, model number, and total acquisition cost are to be provided. *DO NOT USE LOCAL DISTRIBUTORS NAME OR MODEL NUMBER.* The total acquisition cost must include the cost of the requested item plus the costs of all components, accessories, installation and facility modification.

BLOCK 3:
Justification:
a. Instructions on form.
b. Provide statements on the impact of the requested item as to the effect on CHAMPUS, workload, efficiency, productivity, manpower resources, cost reduction, maintenance, etc. Include increases and decreases.
c. Provide information on similar equipment that is currently available at the facility and the usage of that equipment. *ASSISTANCE FROM THE EQUIPMENT MANAGER MAY BE REQUIRED TO COMPLETE THIS INFORMATION.*
d. Provide information on any existing or programmed equipment that the requested item will be used with.
e. Provide information on the impact if the item is not funded in the FY requested (CHAMPUS cost, Supplemental Care cost, leasing required).
f. Self-explanatory. Not applicable (N/A) may be indicated if it is not possible to upgrade the old equipment.
g. If this item is marked "Yes", then the ECN should be an "IH" in the second and third digits.
h. Self-explanatory.

BLOCK 4: Equipment is...Indicate if the equipment is new; expending the capability by having more of the same item on hand; is a replacement; or is upgrading current equipment on hand.
a. To be completed if the requested item is replacing or upgrading a unit currently in use.
b. To be completed if the requested item is replacing a unit currently in use. If the current unit is going to be retained indicate why it will be retained.

BLOCK 5:
Requesting Department Head: Provide typed name, grade, phone number, and signature of the requesting department head.

BLOCK 6:
Is an ASDP Required? *TO BE COMPLETED BY*

THE HEAD, MID. Indicate if an ASDP is required and attach a copy as needed. *SEND ORIGINAL ASDP DIRECTLY TO NAVMEDINFOMGMTCEN.*

BLOCK 7:
Facilities Manager: *TO BE COMPLETED BY THE ASSIGNED CIVIL ENGINEER OR PUBLIC WORKS OFFICER.*

BLOCK 8:
Biomedical Engineering Representative: *TO BE COMPLETED BY THE BIOMEDICAL EQUIPMENT REPRESENTATIVE.* If the item is a nonmedical request, indicate "N/A" in the signature area. Include phone numbers.

BLOCK 9:
Are there any OSHA Requirements? *TO BE COMPLETED BY THE SAFETY OFFICER.* If there are OSHA requirements, please provide an addendum indicating what requirements there are and if the requesting item will meet those requirements.

BLOCK 10:
Reviewed by Equipment Program Review Committee: Provide the typed name and signature of the Chairman, EPRC.

BLOCK 11:
Type of funding: Indicate the type of funding for which the equipment request was completed. Is it for OP, FIP, IT, IH, Collateral (MILCON project), Lease, O&M? Provide the typed name, date, and signature of the Comptroller and Equipment Manager.

BLOCK 12:
Commanding Officer: Provide the typed name, date, and signature of the Commanding Officer.

BLOCK 13:
HSO, NEHC, or NSHS Reviewer. Provide the typed name, date, and signature of the Commanding Officer.